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ABSTRACT

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CHILD CARE MODEL

FOR

URBAN COMMUNITIES

by

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CHILD CARE MODEL FOR URBAN COMMUNITIES

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INTRODUCTION

For the purposes of this presentation, I am defining Child Care as those services rendered to a child, or on behalf of a child, within or without the child's own home, by individuals who are not the natural parents in an effort to effect or to cause to effect positive development in a manner most helpful to the child.

Implicit in this definition is the notion that the process of child caring has to be one that is in harmony with the child's cultural heritage and identity. Indeed, it may be most important for an angry child who has tasted the consequences of being Black in a racist society to learn how to survive rather than to internalize a value system that, by definition, is destructive to him. I shall not address directly the issues related to appropriate role models and effective social change mechanisms that must be in place at the same time one develops comprehensive child care services; i.e., that is the subject of another paper. However, it is important to state straight out that child care, from this writer's point of view, must be community-oriented if it is to be effective.

BACKGROUND

Child care programs historically placed children outside of their communities into facilities that were supposed to provide a changed environment accompanied by a therapeutic program to enhance the child's development or correct certain personality development problems or deal with unacceptable behavior patterns.

While the intent may have been humane, in practice the notion of punishment and the feeling of rejection permeated much of the placement in institutions of children who were difficult to handle in their communities. The less difficult and in some instances perhaps the more fortunate children were placed in

foster homes. Foster homes provide a broad range of environments to which children have to adjust; some are benevolent, some are punitive, others are loving and giving, and still others demanding and fragile.

Halfway houses developed as facilities for bridging the gap between institutional placement and ultimate return to the child's home or substitute home environment (i.e., foster homes or group homes).

Group homes became the service delivery methodology for those children who had no homes to which they could return and needed a viable living arrangement either after a period of institutionalization or in lieu of an institutional program.

Of course, there was always adoption as the ideal plan for those children who were available for adoption. Unfortunately, many, while available, did not meet the criteria of those who were in search of young children or babies in order to build a family.

Family service programs that moved out the grant-in-aid programs to the development of counseling, casework and other psychiatrically-oriented services could have been a vehicle for providing the "cement" that would unify these various fragmented child care programs. However, their middle-class orientation, their inability to effectively confront other institutions and their notion of helping people "adapt to society" precluded their being effective in providing a unifying umbrella for effective child care models.

REMOVAL OF CHILDREN FROM THE COMMUNITY

While the rhetoric of the public and private social agencies involved in providing services to troubled children from multi-problemed families generally speaks to the return of these children to their own families, in practice we find that once in placement, this referral route results in:

a) Retaining the child longer
b) Dispersing the family members

c) Working less with families in their own homes and communities
d) Finding alternative placements for children rather than returning them to their own families and communities

the rationale being that the already "treated" child, for his or her own good, should be in a setting conducive to helping him or her retain the gains already made -- meaning once again, placement away from family and community.

The program constraints, albeit of well meaning child-caring agencies and institutions, "force" rationalizations for further foster care, group homes, placement, etc., because of (1) the physical separation of community systems from child placement systems and (2) the paucity of actually operating comprehensive community programs and the consequent limited options of the child placement systems as these relate to providing the indicated holistic family services that are required to indeed build upon the family and community strengths.

COMPREHENSIVE CHILD CARE MODEL FOR URBAN COMMUNITIES

The existing arrangement of fragmented services can, at best, be called ineffective. At the other end of the scale such phrases as self-interest orientation, institutional racist practices and destructive methodologies might apply.

When we speak of developing a comprehensive child care model for urban communities, we mean to root it in the family and in the neighborhood. Why even think of its existence as being dependent upon facilities or services outside of the community? We mean, moreover, to disregard the constraints of limited allocation of resources. We mean to conceptualize a child care model that precludes the fragmentation of service delivery systems caused by the plethora of funding and accountability routes.

We mean to develop this model from the consumer's vantage point and not twist it to meet the constraints of the provider systems. The comprehensive child care model should evolve from what we want to do and what needs to be done, not from what exists.

New Approaches

To do this, we must take another look at the child-rearing pattern from the vantage point of the Black urban family constellation (or the Puerto Rican or Mexican or Appalachian urban family constellation). For example, the "official" view of the Black urban family constellation is that it is by practice, if not by intent, matriarchal and rigid. The stereotyped role of the Black father is one of being away from the household -- working, disporting, paying occasional visits to the household. The child-rearing role is seen as being the exclusive province of the mother, grandmother or maternal aunt. When agency appointment schedules are basically locked into a 9-to-5 time frame, this stereotype of mother's "availability" and father's "absence" is reinforced by the structure of the system itself. The issue of time availability in this instance raises important questions in other areas. For example, should the time allocated for public education be limited to morning and afternoon weekday hours? Should hospital clinics be open only in the daytime? Should welfare centers close in effect at 3:30 p.m.? Is it wise or practical to cut back services during weekend and summer periods when holistic programs are especially needed to serve an under-employed, city-bound inner city population?

The child care model must become free-flowing, individualized and tailored to the individual situation rather than institutionalized.

Why can't the individualized model be built around the naturally nurturing father, or the uncle in Harlem who sits astride his three-generational family, or the activist older brother, or sister, who is the strong, supportive, achieving family and community spokesman? Why can't the model be tailor-made to capitalize upon the combined strengths of a large extended family where the siblings and cousins maintain and nurture deep mutual family concern and interests? Of critical importance, however, is that whatever the child care model may be, it has to be <u>family-centered</u> rather than just <u>child-centered</u> -- the latter being the actual child care model in use today for disturbed children from "disorganized" families.

The child care model must be a family model that mirrors the multiple options of the extended family/community that organically grow out of the Black family structure (or the Puerto Rican family structure).

Change in Role of Institutions

It follows, naturally, that when we look at the urban child care model from the viewpoint of child and family needs, we see the institutional influences (school, health, welfare, housing, court, employment) playing a critical role in any comprehensive child/family care system. All of these institutional systems must be programmed to build upon the continuity and integrity of service delivery that accentuates family/community strength rather than as is now the almost universal rule, separating/punishing the dysfunctional family in its time of crisis.

When family problems are beyond the coping and solving abilities of the family itself, the program options must be community-based. A number of concrete examples can be cited: neighborhood foster homes must be available, when required, rather than foster homes in the hinterland; short-term community-based residences, not centrally located city shelters, must serve as "crash pads" for youngsters in crisis; agencies must provide specifically trained family-oriented homemaker/organizers to work in the homes of troubled families to keep them intact rather than resorting to the route of institutional placement. Today, when one speaks of providing foster care for children, the automatic assumption is that the youngsters go to where the foster caring is located -- be it a foster family, a foster group residence, a foster care office.

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The concept of a community-based child care model turns this around. It addresses itself to the development of mechanisms and resources that bring the foster caring system into the youngster's family's own home. What an effective base this could become for developing flexible foster care systems tailor-made to individual needs -- utilizing latent manpower from the extended family and the community proper, building in, wherever indicated, the competence required for the community/family itself so it can carry the fostering responsibility for its own members.

The difference between what exists and what we are proposing can be seen in a description of the process involved. Today, the youngster in the inner city comes to the attention of the school attendance officer, the youth division of the local police precinct, the court. To begin with, his parents, along with others in his family and community, see these negatively

balanced institutional personnel antagonistically. Yet, they know that the critical decisions concerning themselves and their children are in the hands of these very antagonists.

The youngster is routed through the juvenile justice system to the point where the Commissioner of Social Services is empowered to act "in loco parentis." The Commissioner calls upon private and public child-caring agencies to accept the youngster and to develop a treatment plan for him. By this time, however, the youngster is effectively removed from family and community.

The community-based child care model works very differently. The services offered to child/family are in the community to begin with. The Police Youth Division is working in partnership with the community youth. Service systems are in operation to maintain the child within his family at points of stress or in delivery systems that retain the youngster in the community with programmed ongoing contact with siblings and family. Should further court or public action be indicated warranting the Social Service Department to assume an "in loco parentis" role, these service personnel are with the youngster and the family throughout the process. Options are sought that include their critical thinking and exploration. Family, community and agency personnel, in essence, are functioning together as ongoing ombudsmen and advocates. Should short-term stays away from home and community, from this vantage point, still be indicated for specialized care, the community team or integrated service staffs will ensure ongoing two-way family and community continuity. Re-entry programming becomes an integral part of the youngster's stay while he is away from home — as opposed to the current practice of isolation.

In short, preventive and interventive strategies can be developed that will underscore the rights and prerogatives of children and parents rather than "nurturing" their feelings of impotence and frustration.

Political Action

As matters now stand, social agencies have no broad-based constituency through which effective lobbying can take place to ensure that the human services receive the priority and funding they require. What a different ballgame it will be when the consumer community is critically involved in directing these services

towards recognizing consumer priorities and meeting their needs and can join with the service providers to form a consumer/community/agency lobby. When we have reached that point, a person's involvement with a social agency will no longer carry a stigma. You don't have to be "crazy" to lobby for mental health.

The function of the social agency changes significantly when we view it from a community-based child care model. The social agency must help to develop and train or retrain a professional and community cadre to function in such a system. They must know how or learn how to use political clout to change federal and state funding patterns that presently insist upon the fragmentation of service programs. What a different climate we would have if the city and state authorities, in developing guidelines and standards for child caring facilities, would pay greater heed to the human and professional dimensions of staffing patterns than to the square footage required per child or the number of fire extinguishers per square foot. This is not meant to downgrade the important intent of such administrative requirements but to point up the impracticality and inappropriateness of the present order of priorities.

To accomplish these goals, the current means of decision-making must be reassessed and a redistribution of power must take place.

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DEVELOPMENT OF WILTWYCK'S COMMUNITY PROGRAM

What I have been saying is not just a series of theoretical notions or well-meaning statements but represents the backdrop against which the agency I direct has been developing its child care program.

We at Wiltwyck have been addressing ourselves to many of the challenges I have touched upon in this paper. We are an agency which was literally created some 35 years ago in order to provide service to the Black, Protestant, court-related child for whom there were no programs other than the state training schools. Through the years, in an effort to respond to the

needs of the youngsters and families we serve, we changed and expanded our services, developing foster home, family therapy, group home and halfway house programs. Yet we remained in an after-the-fact stance -- and the critical problem of "recycling" the child back to his family remained unsolved. Recognition of these continuing service gaps and the wish to be more responsive to the needs of our population led to a decision to develop a visible service presence in the three major areas of the city where the bulk of our children clustered -- Harlem, Bedford-Stuyvesant and the South Bronx.

We began a systematic re-evaluation on many levels of our program purposes and goals -- involving our Board, our staff, our parent constituency and even our youngsters, while opening an ongoing dialogue with the appropriate federal, state and city funding and administrative agencies in order to achieve this critical change in focus.

This process, which at times was slow and painful, entailed an ongoing re-examination of staffing patterns, roles and styles of functioning, a reclarification of internal decision-making mechanisms with regard to intake decisions, referrals to state hospitals and courts, etc. We took a hard look at the implications of the hierarchical unwritten status ladder that caused most staff members to want the title of Therapist with a capital "Th" after their names. While retaining levels of quality, we redirected our therapeutic emphasis to the "living experience."

Internal Program Adjustments

Through meaningful input from our parents' associations, we were able to hear what our parents had been telling us individually for a long time -- namely, that parents' visits were arranged to conform to staff's convenience. We now relate to the time needs of our parents through the operation of a daily shuttle service that brings youngsters into the city and parents to our campus. This, in turn, has important implications for school and residential programs when a functioning PTA begins to operate on campus.

We have grouped the campus population into three units corresponding to the three community target areas and are making every effort to strengthen the programmatic ties between the campus and community units. Our Board has also been decentralized into committees representing the three target areas. Each of these committees

has Board, community and parent representatives and is involved in all phases of planning, implementing and reviewing community programs. In addition, there are three distinct parents' associations as well as a foster parents' association, all of which have ongoing feed-in to program planning operations. Each of the three community service centers is developing its own program according to the special needs and priorities of its own constituency. This does not take place in a vacuum, but in conjunction with the regional and subregional planning groups in the areas.

As our community program developed, specific needs revealed themselves with increasing clarity and urgency. With differing constraints and opportunities in each area over the past two years, these needs were translated into the following program components:

1) We moved our outpatient clinic from the Gramercy Park section of Manhattan directly into the Harlem community and shortly thereafter opened a group home in the same neighborhood.

2) We opened a storefront which offers counseling, a housing clinic, a food co-op, recreation and tutoring services to neighborhood youngsters and families. Aftercare services for our Bronx families also emanate from this center. We opened two group homes in proximity to the storefront.

3) We opened a Day Center and storefront in the Bedford-Stuyvesant section of Brooklyn which offer: specialized educational, vocational, recreational and counseling programs for neighborhood boys and girls 10 to 17 years of age who have behavioral, emotional and learning problems. Services are presented in three formats -- an all-day supervision program for those children who cannot function in the public school, an after-school program to help those who are having difficulty in school, and a special adolescent program with vocational emphasis. These programs are family-oriented and also serve the needs of our Brooklyn aftercare population.

A program development unit is involved on an ongoing basis in identifying gaps in service in the community and in developing a community profile through which to improve our understanding of community needs and ways to meet these needs.

An Information and Referral Service for all residents of the community with a built-in follow-up system is in operation.

A Homemaker/Organizer program, where we recruited neighborhood residents and gave them specialized intensive training enabling them to work with families during a crisis, or in the everyday tasks of home management, is operating. This program was designed to serve the child who might otherwise have been placed and the family torn asunder, but now can be kept at home and his family remain intact.

These specially trained homemakers have been specifically trained to help parents make better use of clinics, schools, recreational facilities, and public service agencies. They can help parents to know their rights and to secure the services to which they are entitled. The results of their training program far surpassed our expectations. The successful creation of a training model, the development of a careful recruitment and selection process, and, finally, the addition to our staff of ten community people capable of performing, with knowledge and competence, a wide range of essential tasks within and without the homes of the multi-problemed families of Bedford-Stuyvesant, are, we feel, important and fundamental accomplishments.

We are also applying for funds to establish a community-based Short-term Coeducational Adolescent Assessment Residence with a family-oriented clinic to obviate the need for youngsters' placement in city shelters but rather to focus on their re-integration within their own families.

Also under review at this time is a proposal we have submitted to the city at its request for the establishment of two community-based group homes for severely disturbed adolescent boys and girls, with built-in outreach programs to facilitate working with their families.

Eleanor Roosevelt Campus

Along with grouping our population to correspond to the three target areas, we are engaged in an ongoing process of interlocking the campus residential units with their community-based counterparts. Intakes from the three target areas will be processed within those areas, with residential treatment being

one option among the existing community-based service delivery systems already functioning in the areas. We are continuing to work on the interrelatedness of the ongoing staff patterns between the residential and community personnel so that continuity of care with child and family replaces fragmented liaison. Re-entry then does not become an end period of flurried activity, but flows organically and smoothly from the residential placement experience.

During this period we have made a number of significant programmatic adjustments in our campus program:

1) The utilization of a part of the infirmary and staff as a psychiatric inpatient service, designed to perform the function of a crisis intervention unit. This innovation has been instrumental in reducing transfers to state hospitals to zero, as contrasted with about ten in previous years.

2) A marked reduction in the use of psychotropic medication as a therapeutic modality. No more than four boys have been on medication at any one time, and the number has usually been less. This contrasts with at least 45 or 50 in previous years.

3) The creation of a special Adolescent Unit not only to increase our programming capability for an age group that we were not geared to serve adequately, thus enabling us to serve older children at our campus facility when needed, but to bridge the gap between a youngster's experience at Wiltwyck and his return to his own home, a group home or a foster home in the community.

CONCLUSION

The real implications of what I have attempted to present in this paper go to the heart of the training, staffing and service patterns of our human/health service delivery systems for inner city populations.

We at Wiltwyck, along with a growing number of citizens and community organizations, are determined to approach these problems with new energy, a willingness to innovate, and a determination to

to succeed. As we create more relevant and effective child care models and as we discover new ways of helping people to break out of and overcome the oppression of their ghetto communities, we will consider it a mandate not only to accelerate the development of these programs, but to join with others who are similarly involved in the struggle, to point the way to all who are working to fortify and enhance the quality of life for children and families of the inner-city.

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